10-010 Payment for Hospital Services:

10-010.01 (Reserved)

10-010.02 (Reserved)

10-010.03 Payment for Hospital Inpatient Services: This subsection establishes the rate-setting methodology for hospital inpatient services for the Nebraska Medical Assistance Program excluding Nebraska Medicaid Managed Care Program's (NMMCP) capitated plans. This methodology complies with the Code of Federal Regulations and the Social Security Act through a plan which:

1. specifies comprehensively the methods and standards used to set payment rates (42 CFR 430.10 and 42 CFR 447.252);
2. provides payment rates which do not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles (42 CFR 447.272); and
3. takes into account the situation of hospitals which serve a disproportionate share of low-income patients (Social Security Act 1902(a)(13)(A)(iv).

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

~~This subsection applies to hospital inpatient discharges occurring on or after October 1, 2009.~~

Payment for hospital inpatient services provided to Medicaid eligible clients is a prospective using methods established by the Department for each participating hospital providing hospital inpatient services except hospitals certified as Critical Access Hospitals.

~~For rates effective October 1, 2009, and later, each~~ Each facility shall receive a prospective rate based upon allowable operating costs and capital-related costs, and, where applicable, direct medical education costs, indirect medical education costs, and a percentage of Medicaid allowable charges based on a hospital-specific cost-to-charge ratio.

10-010.03A Definitions: The following definitions apply to payment for hospital inpatient services.

Allowable Costs: Those costs as provided in the Medicare statutes and regulations for routine service costs, inpatient ancillary costs, capital-related costs, medical education costs, and malpractice insurance cost.

Base Year: The period covered by the most recent final-settled Medicare cost report, which will be used for purposes of calculating prospective rates.

~~Budget Neutrality: Payment rates are adjusted for budget neutrality such that estimated expenditures for the current rate year are not greater than expenditures for the previous rate year, trended forward.~~

Capital-Related Costs: Those costs, excluding tax-related costs, as provided in the Medicare regulations and statutes in effect for each facility's base year.

2. A licensed facility which begins providing hospital inpatient services in a building at a site where those services have not previously been provided; or
3. A licensed facility which is reopened at the same location where hospital inpatient care has previously been provided but not within the previous 12 months.
   Note: A new operational facility is created neither by virtue of a change in ownership nor by the construction of additional beds to an existing facility.

Operating Cost Payment Amount: The calculated payment that compensates hospitals for operating cost, including the major moveable equipment portion of capital-related costs, but excluding the building and fixtures portion of capital-related costs, direct medical education costs, and indirect medical education costs.

Peer Group: A grouping of hospitals or distinct part units with similar characteristics for the purpose of determining payment amounts. Hospitals are classified into one of six peer groups:

1. Metro Acute Care Hospitals: Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The peer group base payment amount is the same for all hospitals in a peer group except for Nebraska Children's Hospitals in Peer Group 1,Peer Group 5 and Peer Group 6.

2. Nebraska-specific relative weights are calculated as follows:

   a. Remove from the claims data all psychiatric, rehabilitation, transplant, Medicaid Capitated Plans, and Critical Access Hospital discharges;
   b. Remove Transfer claims with days less than the DRG average length of stay;
   c. Remove statistical outlier claims with estimated costs 3 times the DRG standard deviation above or below the DRG mean cost per discharge for each DRG;
   d. Remove claims with low volume DRGs with less than 10 claims;
   e. Of the remaining claims, conduct a stability test to using a statistical sample size calculation formula to determine the minimum number of claims within each DRG classification needed to calculate stable relative weights. Calculate the required size of a sample population of values necessary to estimate a mean cost value with 90 percent confidence and within an acceptable error of plus or minus 20 percent given the populations estimated standard deviation.
   f. Remove claims with unstable DRGs without sufficient numbers of claims to pass the stability test
   g. Of the remaining claims, determine the arithmetic mean Medicaid cost per discharge for each DRG by dividing the sum of all Medicaid cost for each DRG by the number of discharges;
   h. Of the remaining claims, determine the statewide arithmetic mean Medicaid cost per discharge by dividing the sum of all costs for all discharges in the State by the number of discharges;
   i. For each remaining, or stable DRG, divide the DRG arithmetic mean Medicaid cost per discharge by the statewide arithmetic mean Medicaid cost per discharge to determine the DRG relative weight;

10-010.03B1b Calculation of the Starting Point for the Nebraska Peer Group Base Payment Amounts: Peer Group Base Payment Amounts are used to calculate payments for discharges with a stable DRG. For purpose of rate setting, the starting point shall be the Medicaid Peer Group Base Payment Amount effective on July 1 of state fiscal year (SFY) 2010. ~~Peer Group Base Payment Amounts effective October 1, 2009 are calculated for Peer Group 1, 2 and 3 hospitals based on the Peer Group Base Payment Amounts effective during SFY 2007, adjusted for budget neutrality, calculated as follows:~~

~~1. Peer Group 1 Base Payment Amounts, Excluding Children's Hospitals: Multiply the SFY 2007 Peer Group 1 Base Payment Amount of $3,844.00 by the Stable DRG budget neutrality factor.~~
~~2. Children's Hospital Peer Group 1 Base Payment Amounts, Excluding Children's Hospitals: Multiply the SFY 2007 Children's Hospital Peer Group 1 Base Payment Amount of $4,614.00 by the Stable DRG budget neutrality factor.~~
~~3. Peer Group 2 Base Payment Amounts: Multiply the SFY 2007 Peer Group 2 Base Payment Amount of $3,733.00 by the Stable DRG budget neutrality factor.~~
~~4. Peer Group 3 Base Payment Amounts: Multiply the SFY 2007 Peer Group 3 Base Payment Amount of $3,535.00 by the Stable DRG budget neutrality factor.~~

~~SFY 2007 Nebraska Peer Group Base Payment Amounts are described in 471 NAC 10-010.03B4 in effect on September 1, 2007 and 471 NAC 10-010.03B in effect on July 1, 2001.~~

~~Peer Group Base Payment Amounts will be increased by 0.5% for the rate period beginning October 1, 2009 and ending June 30, 2010. This rate increase will not be carried forward in subsequent years. Peer Group Base Payment Amounts excluding the 0.5% increase for the rate period beginning October 1, 2009 and ending June 30, 2010, will be inflated by .5% for the rate period beginning July 1, 2010.~~

SFY 2010 Peer Group Base Payment Amounts are described in 471 NAC 10-010.03B1b in effect July 1, 2010.

10-010.03B1b(1) Application of Adjustment Based on Legislative Appropriations: The starting point for the peer group base payment amounts, as determined in section 10-010.03B1b, shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The Peer Group Base Payment Amounts are adjusted annually and shall be effective each July 1.

10-010.03B2 Calculation of Stable DRG Cost Outlier Payment Amounts: Additional payment is made for approved discharges classified into a stable DRG meeting or exceeding Medicaid criteria for cost outliers for each stable DRG classification. Cost outliers may be subject to medical review.
Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus ~~$50,000~~ $53,000. Cost of the discharge is calculated by multiplying the Medicaid allowed charges by the sum of the hospital specific Medicare operating and capital outlier CCRs. Additional payment for cost outliers is 80% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 85%.

10-010.03B2a Hospital Specific Medicare Outlier CCRs: The Department will extract from the CMS PPS Inpatient Pricer Program the hospital-specific Medicare operating and capital outlier CCRs effective October 1 of the year preceding the start of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier CCRs effective in the Medicare system on October 1, 2008.

10-010.03B2b Outlier CCRs Updates: On July 1 of each year, the Department will update the outlier CCRs based on the Medicare outlier CCRs effective October 1 of the previous year.

10-010.03B3 Calculation of Stable DRG Medical Education Costs

10-010.03B3a Calculation of Stable DRG Direct Medical Education Cost Payments:

For discharges with stable DRGs, Direct Medical Education (DME) payments ~~effective October 1, 2009~~ are based on Nebraska hospital-specific DME payment rates effective during SFY ~~2007~~ 2010 ~~with the following adjustments:~~

~~1. Estimate SFY 2007 DME payments for in-state teaching hospitals by applying SFY 2007 DME payment rates to SFY 2007 Nebraska Medicaid inpatient fee-for-service paid claims data. Include discharges with stable DRGs, unstable or low volume DRGs and transplant DRGs. Exclude all psychiatric, rehabilitation and Medicaid Capitated Plans discharges.~~
~~2. Divide the estimated SFY 2007 DME payments for each hospital by each hospital's number of intern and resident FTEs effective in the Medicare system on October 1, 2006.~~
~~3. Multiply the SFY 2007 DME payment per intern and resident FTE by each hospital's number of intern and resident FTEs effective in the Medicare inpatient system on October 1, 2008.~~
~~4. Divide the DME payments adjusted for FTEs effective October 1, 2008 by each hospital's number of SFY 2007 claims.~~
~~5. Multiply the DME payment rates by the stable DRG budget neutrality factor.~~

SFY ~~2007~~ 2010 Nebraska hospital-specific DME payment rates are described in 471 NAC 10-010.03B in effect ~~September 1, 2007~~ July 1, 2010. Each SFY Nebraska hospital-specific DME payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The DME payment rates are adjusted annually and shall be effective each July 1.

On July 1st of each year, the Department will update DME payment rates by replacing each hospital's intern and resident FTEs ~~effective in the Medicare inpatient system on October 1, 2008, as described in step 3 of this subsection,~~ with each hospital's intern and resident FTEs effective in the Medicare inpatient system on October 1 of the previous year. ~~The direct medical education payment amount will be increased by 0.5% effective October 1, 2009 through June 30, 2009. This rate increase will not be carried forward in subsequent years. The direct medical education payment amount, excluding the 0.5% increase effective October 1, 2009 through June 30, 2009, will be increased by .5% for the rate period beginning July 1, 2010.~~

10-010.03B3b Calculation of Stable DRG Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from the Department, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the operating cost payment amount.

The IME factor is the Medicare inpatient prospective payment system operating IME factor effective October 1 of the year preceding the beginning of the Nebraska rate year. The operating IME factor shall be determined using data extracted from the CMS PPS Inpatient Pricer Program. For rates effective October 1, 2009, the Department will determine the operating IME factors effective for the Medicare system on October 1, 2008 using the following formula:

$[\{1+(\text{Number of Interns and Residents/Available Beds})\}^{0.405}-1] * 1.35$

On July 1st of each year, the Department will adopt the Medicare inpatient prospective payment system operating IME factor formulas and rate components in effect on October 1st of the previous year.

10-010.03B3c Calculation of Managed Care Organization (MCO) Medical Education Payments: The Department will calculate annual MCO Direct Medical Education payments and MCO Indirect Medical Education payments for services provided by NMMCP capitated plans from discharge data provided by the ~~hospital~~ plans.

1. MCO Direct Medical Education payments will be equal to the number of MCO discharges times the MCO direct medical education payment per discharge. The MCO direct medical education payment per discharge is the hospital specific fee-for-service DME payment rates for stable DRGs, unstable or low volume DRGs and transplant DRGs,

~~a. The MCO direct medical education payment per discharge is the hospital-specific weighted average fee-for-service DME payment rates for stable DRGs, unstable or low volume DRGs and transplant DRGs, as described in 471 NAC 10-010.03B3a, 10-010.03B5b and 10-010.03B6b. The weighted average amount shall be based on the claims included in the Fiscal Simulation Analysis as described in 471 NAC 10-010.03B7a.~~

~~b. On July 1st of each year, the Department will update the Direct Medical Education payment rates. The Direct Medical Education rates will be increased or decreased based on the annual percentage change in the number of intern and resident FTEs used for the calculation of the Stable DRG Direct Medical Education Cost Payments described in subsection 471 NAC 10-010.03B3a.~~

2. MCO Indirect Medical Education payments will be equal to the number of MCO discharges times the MCO indirect medical education payment per discharge. The indirect medical education payment per discharge is calculated as follows:

   ~~a.~~ Subtotal each teaching hospital's fee-for-service inpatient acute indirect medical education ~~simulated~~ payments ~~using the~~ for stable DRG claims ~~in the Department's Fiscal Simulation Analysis~~ from the prior SFY. ~~Exclude unstable/low volume DRG and transplant DRG claims. Fee-for-service indirect medical education payments for stable DRG claims are described in 471 NAC 10-010.03B3b.~~

   b. Subtotal each teaching hospital's fee-for-service inpatient acute ~~stable DRG claim~~ covered charges from the prior SFY.~~, inflated to the midpoint of the rate year, in the Department's Fiscal Simulation Analysis. Exclude unstable/low volume DRG and transplant DRG claims. The Fiscal Simulation Analysis is described in 471 NAC 10-010.03B7a.~~

   c. Divide each teaching hospital's ~~simulated~~ indirect medical education payments, as described in subsection a. above, by ~~inflated~~ covered charges, as described in subsection b. above.

   ~~d.~~ Multiply the ratio described in subsection c. above times the covered charges in MCO paid claims for the rate period. ~~in the base year, inflated to the midpoint of the rate year.~~

   e. Divide the amount calculated in subsection d. above by the number of MCO paid claims in the base year.

   ~~f. On July 1st each year, the Department will update the indirect medical education payment per discharge. The indirect medical education payment per discharge amount will be increased or decreased based on the annual percentage change in Medicare's indirect medical education factor during the year.~~

10-010.03B4 Calculation of Stable DRG Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis for stable DRGs. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of stay for the stable DRG. Capital-related payment per diem amounts ~~effective October, 1, 2009~~ are calculated for Peer Group 1, 2, and 3 hospitals based on the Capital-related payment per diem amounts effective during SFY 2010. ~~2007, adjusted for budget neutrality, as follows:~~

~~1. Peer Group 1 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 1 Capital-related payment per diem amount of $36.00 by the Stable DRG budget neutrality factor.~~
~~2. Peer Group 2 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 2 Capital-related payment per diem amount of $31.00 by the Stable DRG budget neutrality factor.~~
~~3. Peer Group 3 Capital-Related Payment Per Diem Amounts: Multiply the SFY 2007 Peer Group 3 Capital-related payment per diem amount of $18.00 by the Stable DRG budget neutrality factor.~~

~~SFY 2007~~ The Base Capital-Related Cost Payment~~s~~ per diem amounts are described in ~~471 NAC 10-010.03B7~~ 10-010.03B4 in effect on July 1, 2010. ~~August 25, 2003.~~ Each SFY the peer group specific capital-related payment per diem amounts shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The capital-related payment rates are adjusted annually and shall be effective each July 1.

10-010.03B5 Low Volume and Unstable DRG Payments: Discharges that are classified into a Low Volume or Unstable DRG are paid a Low Volume and Unstable DRG CCR payment and, if applicable, a DME payment. Low Volume and Unstable DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payment or Capital-Related Cost Payments.

10-010.03B5a Low Volume and Unstable DRG: CCR Payments are calculated by multiplying the hospital-specific Low Volume/Unstable DRG CCR by Medicaid allowed claim charges~~. Low Volume/Unstable DRG CCRs are calculated as follows:~~

~~1. Extract from the CMS PPS Inpatient Pricer Program for each hospital the Medicare inpatient prospective payment system operating and capital outlier CCRs effective October 1 of the year preceding the beginning of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier CCRs in effect for the Medicare system on October 1, 2008.~~
~~2. Sum the operating and capital outlier CCRs.~~
~~3. Multiply the sum of the operating and capital outlier CCRs by the Low Volume / Unstable DRG budget neutrality factor.~~

On July 1 of each year, the Department will update the Low Volume/Unstable DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years. ~~before budget neutrality adjustments.~~ Each SFY Nebraska hospital-specific low volume and unstable DRG CCR payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The low volume and unstable DRG CCR payment rates are adjusted annually and shall be effective each July 1.

10-010.03B5b Low Volume and Unstable DRG DME Payments: Low Volume and Unstable DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation.~~, with the exception that in step 4, per discharge payment amounts are adjusted by the Low Volume/Unstable DRG budget neutrality factor.~~

On July 1st of each year, the Department will update Low Volume and Unstable DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.

10-010.03B6 Transplant DRG Payments: Transplant discharges, identified as discharges that are classified to a transplant DRG, are paid a Transplant DRG CCR payment and, if applicable, a DME payment. Transplant DRG discharges do not receive separate Cost Outlier Payments, IME Cost Payments or Capital-Related Cost Payments.

10-010.03B6a Transplant DRG CCR Payments: are calculated by multiplying the hospital-specific Transplant DRG CCR by Medicaid allowed claim charges. ~~Transplant DRG CCRs are calculated as follows:~~

~~1. Extract from the CMS PPS Inpatient Pricer Program for each hospital the Medicare inpatient prospective payment system operating and capital outlier CCRs effective October 1 of the year preceding the beginning of the Nebraska rate year. For rates effective October 1, 2009, the Department will extract the outlier CCRs in effect for the Medicare system on October 1, 2008.~~

~~2. Sum the operating and capital outlier CCRs.~~
~~3. Multiply the sum of the operating and capital outlier CCRs by the Transplant DRG budget neutrality factor.~~

On July 1 of each year, the Department will update the Transplant DRG CCRs based on the percentage change in Medicare outlier CCRs effective October 1 of the two previous years.~~, before budget neutrality adjustments.~~ Each SFY Nebraska hospital-specific transplant DRG CCR payment rates shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The low volume and unstable DRG CCR payment rates are adjusted annually and shall be effective each July 1.

10-010.03B6b Transplant DRG DME Payments: Transplant DRG DME payments are calculated using the same methodology described in subsection 10-010.03B3a of this regulation~~, with the exception that in step 4, DME per discharge payment amounts are adjusted by the Transplant DRG budget neutrality factor.~~

On July 1st of each year, the Department will update Transplant DRG DME payment per discharge rates as described in 10-010.03B3a of this regulation.

~~10-010.03B7 Budget Neutrality Factors: Peer Group Base Payment Amounts, Capital-Related Cost Payments, Direct Medical Education Cost Payments, Low Volume/Unstable DRG CCRs and Transplant DRG CCRs are multiplied by budget neutrality factors, determined as follows:~~

~~10-010.03B7a Develop Fiscal Simulation Analysis: The Department will develop a fiscal simulation analysis using Nebraska Medicaid inpatient fee-for-service paid claims data from the most recently available and fully adjudicated state fiscal year from all Peer Group 1, 2 and 3 in-state hospitals and claims from out-of-state hospitals with at least $500,000 in payments and 50 claims in the two year claims dataset used for the relative weight calculation. Include discharges with stable DRGs, unstable or low volume DRGs and transplant DRGs. Exclude all psychiatric, rehabilitation and Medicaid Capitated Plans discharges. For rates effective October 1, 2009, the Department will create a fiscal simulation analysis using SFY 2007 claims data.~~

~~In the fiscal simulation analysis, the Department will apply all rate year payment rates before budget neutrality adjustments to the claims data and simulate payments.~~

~~10-010.03B7b Determine Budget Neutrality Factors: The Department will set budget neutrality factors in fiscal simulation analysis such that simulated payments are equal to the claims data reported payments, inflated by Peer Group Base Payment Amount increases approved by the Department from the end of the claims data period to the rate year. For rates effective October 1, 2009, the Department will inflate the SFY 2007 reported claim payments by 5.45%.~~

~~The Department will develop separate budget neutrality factors for stable DRG discharges, low volume/unstable DRG discharges and transplant DRG discharges as follows:~~

1. ~~Set the Stable DRG budget neutrality factor applied to stable DRG Peer Group Base Payment Amounts, Capital-Related Cost Payments and DME Cost Payments in the fiscal simulation analysis such that stable DRG claim simulated payments are equal to the stable DRG claims data inflated reported payments.~~
2. ~~Set the Low Volume / Unstable DRG budget neutrality factor applied to low volume/unstable DRG CCRs and DME Cost Payments in the fiscal simulation analysis such that low volume/unstable DRG claim simulated payments are equal to the low volume/unstable DRG claims data inflated reported payments.~~
3. ~~Set the Transplant DRG budget neutrality factor applied to transplant DRG CCRs and DME Cost Payments in the fiscal simulation analysis such that transplant DRG claim simulated payments are equal to the transplant DRG claims data inflated reported payments.~~

10-010.03B8 Facility Specific Upper Payment Limit: Facilities in Peer Groups 1, 2, and 3 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services shall not exceed 110% of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

10-010.03B8a Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report. A final reconciliation will be made within 6 months following receipt by the Department of the facility's final settled cost report.

Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110% of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment

that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

10-010.03B9 Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

10-010.03D1 For payment of inpatient hospital psychiatric services, ~~effective July 1, 2010, the tiered per diem rates will be:~~ for the purpose of rate setting, the starting point shall be the tiered per diem amount effective on July 1 of state fiscal year (SFY) 2010. The starting point shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The tiered per diem amounts are adjusted annually and shall be effective each July 1.

~~Days of Service~~	~~Per Diem Rate~~
~~Days 1 and 2~~	~~$691.10~~
~~Days 3 and 4~~	~~$638.84~~
~~Days 5 and 6~~	~~$609.81~~
~~Days 7 and greater~~	~~$580.77~~

~~The tiered per diem rates listed above were increased by .5% effective for the rate period beginning July 1, 2010.~~

~~10-010.03D2 Payment for Hospital Sponsored Residential Treatment Center Services: Payments for hospital sponsored residential treatment center services are made on a prospective per diem basis. Beginning July 1, 2001, this rate will be determined by the Department and will be based on historical and future reasonable and necessary cost of providing the service. Specific costs to be included in the rate will not be inconsistent with those identified in 471 NAC 32-001.12.~~

10-010.03D2 Payment for Hospital Sponsored Psychiatric Residential Treatment Facilities (PRTFs): Payments for hospital sponsored PRTFs are made on a prospective per diem basis. The starting point for the rate was developed using standardized expense reports. Medicaid will not pay more than the facility's usual and customary daily charges billed for eligible clients. Pharmacy and physician services may be billed separately apart from the facility per diem. Public PRTFs will be cost-settled annually. Payment rates do not include costs of providing educational services. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The prospective payment amounts are adjusted annually and shall be effective each July 1.

10-010.03D3 Payment for Psychiatric Adult Inpatient Subacute Hospital Services: Payments for psychiatric adult inpatient subacute hospital services are made on a per diem basis. ~~This rate may be reviewed annually. Effective April 12, 2008, the payment for psychiatric adult subacute inpatient hospital services identified in state regulations was $488.13. Beginning July 1, 2008, the per diem rate was $505.21 and on November 24, 2009 onward the rate is $512.79. On July 1, 2010, there will be a .5% rate increase.~~ The subacute inpatient hospital per diem rate is not a tiered rate. Payment will be an all inclusive per diem, with the exception of physician services. The starting point shall be the per diem amount effective on July 1 of state fiscal year (SFY) 2010. The starting point shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The per diem payment amounts are adjusted annually and shall be effective each July 1.

10-010.03E Payments for Rehabilitation Services: Payments for rehabilitation discharges are made on a prospective per diem.

All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of –

1. The hospital-specific base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of approved patient days.

Payment is made for the day of admission but not for the day of discharge.

10-010.03E1 Calculation of Hospital-Specific Base Payment Amount: The hospital-specific base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units.

10-010.03E2 Adjustment of Hospital-Specific Base Payment Amount: ~~The hospital-specific per diem rates will be inflated by 2% effective October 1, 2009. The hospital-specific per diem rates will be inflated by .5% for the rate period beginning July 1, 2010.~~ Each SFY. the hospital-specific base payment amount shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The hospital-specific base payment amounts are adjusted annually and shall be effective each July 1.

10-010.03E3 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem as described in 471 NAC 10-010.03B7 in effect on August 25, 2003.

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): ~~Effective for cost reporting periods beginning July 1, 1999, and after~~ Ppayment for inpatient services of a CAH is ninety seven point five percent (97.5%) of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

10-010.03G Rates for State-Operated IMD's: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD's will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for NMAP. This requirement does not apply to a hospital:
   a. The inpatients of which are predominantly individuals under 18 years of age; or
   b. Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.
   c. For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
2. Only Nebraska hospitals which have a current enrollment with the Nebraska Medicaid Assistance Program will be considered for eligibility as a Disproportionate Share Hospital.

10-010.06 Payment for Outpatient Hospital and Emergency Room Services: ~~For services provided on or after July 1, 2011,~~ T~~t~~he Department pays for outpatient hospital and emergency services with a rate which is the product of:

1. ~~Seventy five (75)~~ Seventy three (73) percent of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form CMS-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The effective date of the cost-to-charges ratio is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49). Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services at ninety seven point five (97.5) percent of the fee schedule determined by CMS. See 471 NAC ~~10-003.04G3h~~ 10-003.05F5b.

The starting point for the outpatient hospital and emergency services rate shall be the rates in effect July 1, 2010. The outpatient hospital and emergency services rate shall be adjusted by a percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the Nebraska Legislature. The outpatient hospital and emergency services rate amounts are adjusted annually and shall be effective each July 1.

10-010.06A Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: ~~Effective for cost reporting periods beginning after July 1, 1999~~, P~~p~~ayment for outpatient services of a CAH is ninety seven point five (97.5) percent of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. NMAP will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made in ~~accordance with reasonable cost principles~~ at ninety seven point five (97.5) percent of the reasonable cost of providing these services. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, NMAP will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

10-010.06B Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to 471 NAC 10-010.06, Payment for Outpatient Hospital and Emergency Room Services, unless the

HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made according to 471 NAC 26-005.

10-010.06C Payment for Outpatient Mental Health and Substance Abuse Services in a Hospital: Providers shall use HCPCS procedure codes when submitting claims to the Department for Medicaid services. These codes are defined by the Health Care Common Procedure Coding System (HCPCS). These five-digit codes and two-digit modifiers are divided into two levels:

10-010.06D Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for an emergency medical condition, (see emergency medical condition in 471 NAC 10-001.02);
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by his or her physician for treatment in an emergency room.

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency medical condition and bill accordingly.

When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of what would otherwise be allowed. All other Medicaid allowable charges incurred in this type of visit will be paid at ~~75%~~ 73% of the ratio of cost-to-charges.

10-010.06E Diagnostic and Therapeutic Services: The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as state fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

10-010.06F Payment to a New Hospital for Outpatient Services: See the definition of a new operational facility in 471 NAC 10-010.03A, Payment to a new hospital (a new operational facility) will be made at ~~75%~~ 73% of the statewide average ratio of cost to charges for Nebraska hospitals ~~as of July 1 of that year~~ as determined by the Department. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department using ~~75%~~ 73% of the statewide average ratio of cost to charges.

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services. (For a complete description of payment for outpatient services, see 471 NAC 10-010.06 ff.).

10-010.06G Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges times ~~75%~~ 73% for all Nebraska hospitals. ~~for that fiscal year as of July 1 of that year~~.